Health and Wellbeing Board
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QUALITY PREMIUM INDICATORS 2015/16

Responsible Officer
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1. Summary

The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. Guidance relating to the Quality Premium Indicators for 2015/16 was received by Shropshire CCG on 31 March 2015.

The quality premium, paid to CCGs in 2016/17, reflects the quality of the health services commissioned by them in 2015/16 and will be based on measures that cover a combination of national and local priorities

The guidance stipulates that CCGs and Health & Wellbeing Boards should work together to agree two locally determined indicators that align with Health & Wellbeing priorities.

In addition to these local measures, the CCG Board has considered national measures. Their selections are also presented to the Health & Wellbeing Board for agreement.

2. Recommendations

National measures:

Urgent and Emergency care measures

The CCG has opted for both measures Ai and B, allocating 20% and 10% of the quality premium payment to each measure respectively.

Measure Ai - Avoidable Emergency Admissions Composite measure - a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16. The CCG achieved an 11.5% reduction against this measure in 2014/15 putting it is a very strong position to achieve this quality premium measure.

Measure B – DTOC performance has been worse in 2014/15 than in the previous year. This allows a reasonable margin for improving performance in 2015/16 and achieving the measure

Following consideration the CCG felt it most appropriate to split the quality premium payment across two measures, but to weight the proportion towards the strongest indicator.

Mental Health measures

The CCG has opted for Measure A, allocating 30% of the quality premium payment to this measure.

Measure A – Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.

Local measures
The following indicators are recommended to the Health & Wellbeing Board for approval on the basis of their alignment to the Health & Wellbeing and Better Care Fund priorities, the ability to make progress in year and the data available:

- People with diabetes diagnosed less than 1 year referred to structured education

Performance against this indicator allows room for improvement within 2015/16. Currently patients can be referred into the structured education programme by a GP, diabetic specialist or by self referral. The SCHT diabetic referral team currently record referrals and attendances and if this indicator is chosen this information can be shared on a monthly basis. This indicator also builds on the processes used for the COPD indicator chosen for 2014/15 so we would be embedding knowledge and understanding for our patient groups but also embracing a culture of referral to education for our patients from our practices. In addition, in year there are already plans to look at the way education is delivered for Diabetes and therefore this also aligns with our commissioning intentions and the national focus on Diabetes.

- Hip Fracture: Multifactorial risk assessment of future falls

This work aligns to the work already in train for the prevention strand of the Better Care Fund. Our current performance allows room for improvement and a significant number of CCG's are achieving 100%. There are proposals being considered for the further development of our falls provision which would support this indicator. However, some focused work with key provider staff to ensure the universal use of multifactorial assessment could increase our performance in this area without further investment.

REPORT

Context

The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. Guidance relating to the Quality Premium Indicators for 2015/16 was received by Shropshire CCG on 31 March 2015.

The quality premium, paid to CCGs in 2016/17, reflects the quality of the health services commissioned by them in 2015/16 and will be based on the following measures that cover a combination of national and local priorities. These are:

1) **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);

2) **Urgent and emergency care**-a menu of measures worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

3) **Mental health**- a menu of measures worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

4) **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

5) **Two local measures** which should be based on local priorities such as those identified in joint

health and wellbeing strategies (20 per cent of quality premium -10 per cent for each measure).

The guidance stipulates that CCGs and Health & Wellbeing Boards should work together to agree the two locally determined indicators that align with Health & Wellbeing priorities. Following lengthy consideration of the local measures recommended in this paper including input from the CCG Board and the Health & Wellbeing Delivery group, this report sets out two recommended indicators from a range of options

In addition to these local measures, the CCG Board has considered measures in categories 1-4 and their selections are also be presented to the Health & Wellbeing Board for agreement. Further details of these are set out below.

The health & Wellbeing Board should note that Quality premium measures 1 and 4 (Reducing potential years of life lost and antibiotic prescribing) are fixed requirements and as such the CCG Board has to accept these measures.

Quality premium measures are usually taken from the overall prescribed CCG Outcome Indicator Set (CCG Outcome Indicator Set 2014/15: technical guidance) However, CCG's can choose to develop their own local measure linked to referral or demand management subject to approval from NHS England. It is not proposed on this occasion that a locally developed measure outside the indicator set be adopted.

The Measures for consideration

Urgent and emergency care
The following menu of measures is worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

A) Avoidable Emergency Admissions Composite measure

ii) a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16 ; or

ii) the Indirectly Standardised Rate of admissions in 2015/16 at less than 1,000 per 100,000 population.

B) Delayed Transfers of Care (DTOC) which are an NHS responsibility

C) Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.

Mental Health
The following menu of measures is worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

A) Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.

B) Reduction in the number of people with severe mental illness who are currently smokers

C) Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.

D) Improvement in the health related quality of life for people with a long term mental health condition

The following indicators were selected by the CCG Board:

Urgent and Emergency care measures

It is recommended that for this measure the CCG opts for both measures Ai and B, allocating 20% and 10% of the quality premium payment to each measure respectively.

Measure Ai - Avoidable Emergency Admissions Composite measure - a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16. The CCG achieved an 11.5% reduction against this measure in 2014/15 putting it is a very strong position to achieve this quality premium measure.

Measure B – DTOC performance has been worse in 2014/15 than in the previous year. This allows a reasonable margin for improving performance in 2015/16 and achieving the measure

Following consideration the CCG felt it most appropriate to split the quality premium payment across two measures, but to weight the proportion towards the strongest indicator.

Mental Health measures

It is recommended that for this measure the CCG opts for Measure A, allocating 30% of the quality premium payment to this measure.

Measure A – Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.

The CCG is already achieving both elements of this measure. However, it should be noted that as waiting times in A&E improve performance in relation to those patients with mental health issues will need to improve proportionality.

After consideration the CCG agreed that this was the only measure in the mental health section that should be considered due to lack of robust data or implementation issues relating to the other measures and therefore the full 30% payment has been allocated in this case.

The Local Measures for consideration

The guidance stipulates that CCGs and Health & Wellbeing Boards should work together to agree the two locally determined indicators that align with Health & Wellbeing priorities, these priorities are set out below.

Shropshire's Health & Wellbeing priorities as set out in the Health & Wellbeing Strategy are:
Priority 1 – Health Inequalities are reduced
Priority 2 - People are empowered to make better lifestyle and health choices for their own and their family's health and wellbeing
Priority 3 – Better emotional and mental health and wellbeing for all
Priority 4 - Older people and those with long term conditions will remain independent for longer
Outcome 5 - Health, social care and wellbeing services are accessible, good quality and 'seamless'

A review of the entire CCG Outcomes Indicator Set was carried out and those indicators which align with the Health and Wellbeing Strategy priority areas and work streams under the Better Care Fund were identified. Items where data was not available were removed from the list. The following indicators were considered in more detail:

- Hip Fracture: Incidence – the rate of people admitted with a primary diagnosis of hip fracture per 100,000 of population
- People with diabetes who have received the nine care processes
- People with diabetes diagnosed less than 1 year referred to structured education
- Hip Fracture: multifactorial risk assessment of future falls risk
- Alcohol admissions (primary diagnosis)
- Alcohol readmissions (primary diagnosis)
- Improving experience of healthcare for people with mental illness

Details of the latest available Shropshire CCG performance is set out below. The data is taken from the Health & Social Care information Centre.

Hip Fracture: Incidence – the rate of people admitted with a primary diagnosis of hip fracture per 100,000 of population

Hip fracture is the most common reason for admission to an orthopaedic trauma ward and the incidence is projected to rise.

In 2013/14 of 88,451 patients admitted to an orthopaedic trauma ward 219 were for hip fractures. This gives a standardized rate of 249.6 admissions per 100,000 of population. The standardized England average is 439.1. Shropshire is therefore performing considerably better than the England average

People with diabetes who have received the nine care processes

This indicator measures the percentage of patients with both type 1 and type 2 diabetes who have received the basic health checks for:

- Weight and BMI management
- Blood pressure
- Smoking status
- Blood tests
- Urinary albumin test
- Serum creatinine test
- Cholesterol levels
- Eye check
- Foot check

Since the indicator was published the eye check has been removed from the process so the measures include *eight* care processes

The following table sets out the Shropshire and England average positions. This data is taken from the National Diabetes Audit (NDA) by which performance would be monitored:

	2010/11	2011/12	2012/13
Shropshire CCG	52.0%	51.0%	54.4%
England & Wales	60.6%	60.5%	59.9%

Shropshire's performance has seen an overall improvement it is still below the England/ Wales average.

Although we know that some of our practices are underperforming against some of the NDA measures and steps are being taken to improve these the NDA use data that is 18 months old and it is therefore likely that any data used for performance against the quality premium indicator cannot not be influenced and will not be affected by improvements we make in 2015/16.

Smoking is one of our lowest scoring areas in relation to the 8 care processes. However, there is currently a discrepancy between the data codes used by the NDA and the practices in recording and reporting on this activity. Whilst discussions are taking place in relation to this we cannot be confident that this matter will be resolved in the timescale required to support choosing this quality premium indicator.

People with diabetes diagnosed less than 1 year referred to structured education

The most recent data is for 2011/12 and shows that of the 490 individuals diagnosed in that period, 9.8% were referred on to a structured education programme. Shropshire sits at 98th position out of 203 CCGs placing it at the top of the third quartile

Performance against this indicator allows room for improvement within 2015/16. Currently patients can be referred into the structured education programme by a GP, diabetic specialist or by self referral. The SCHT diabetic referral team currently record referrals and attendances and if this indicator is chosen this information can be shared on a monthly basis. This indicator also builds on the processes used for the COPD indicator chosen for 2014/15 so we would be embedding knowledge and understanding for our patient groups but also embracing a culture of referral to education for our patients from our practices. In addition, in year there are already plans to look at the way education is delivered for Diabetes and therefore this also aligns with our commissioning intentions and the national focus on Diabetes.

Hip Fracture: multifactorial risk assessment of future falls risk
For the 2013 calendar year 88.3% of patients with a hip fracture received a multifactorial assessment of future falls risk. Shropshire was 169th of 233 CCGs putting it in the bottom quartile for this indicator. 68 of the 233 CCGs were achieving 100%

This work aligns to the work already in train for the prevention strand of the Better Care Fund. Our current performance allows room for improvement and a significant number of CCG's are achieving 100%. There are proposals being considered for the further development of our falls provision which would support this indicator. However, some focused work with key provider staff to ensure the universal use of multifactorial assessment could increase our performance in this area without further investment.

Alcohol admissions
Data for this indicator is based on our Acute provider. Data for 2013/14 shows that of 299,002 patients 163 were admitted with a primary diagnosis of alcohol. The standardized rate per 100,000 of population is 52.8. This puts Shropshire in the top 20 performers against this indicator

Alcohol readmissions
Data for this indicator is based on our Acute provider. Date for this indicator is compiled on a rolling basis from April 2011 to March 2014 and gives us a standardized rate of 104.7 readmissions with a primary diagnosis of alcohol per 100,000 of population. This places Shropshire 72 out of 210 CCGs and puts us in the third quartile.

Improving experience of healthcare for people with mental illness
This indicator is based on SSSFT as the provider and is taken from the weighted average of 4 survey questions with scores out of 100.
For 2013 the England average performance was 85.8 with Shropshire's performance sitting above this at 86.4.

Recommendations
Having reviewed the indicators set out above, the available data and performance it is proposed that the following indicators be recommended to the Health & Wellbeing Board for approval on the basis of their alignment to the Health & Wellbeing and Better Care Fund priorities, the ability to make progress in year and the data available:

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- Hip Fracture: Multifactorial risk assessment of future falls

This work aligns to the work already in train for the prevention strand of the Better Care Fund. Our current performance allows room for improvement and a significant number of CCG's are achieving 100%. There are proposals being considered for the further development of our falls provision which would support this indicator. However, some focused work with key provider staff to ensure the universal use of multifactorial assessment could increase our performance in this area without further investment.

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Those for a who have considered the Quality premium Indicators have done so on the basis of choosing those indicators which pose the least risk to the CCG and are the most likely to achieve

4. Financial Implications

There are no financial implications per se. Quality premium measures are paid in arrears and as such are not built into any financial planning assumptions until such time as they are realised

5. Background

Please see above report

6. Additional Information

7. Conclusions

Please see above report

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr Karen Calder
Local Member **Applies to all constituencies**
Appendices -